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ConnectiCare Benefits At A Glance

Affordable, quality health coverage for all offered through Access Health CT. Learn more at ConnectiCareSales.com.

Call today! (866) 714-8990 (TTY: 711)

	Choice Bronze Alternative POS with Dental and Vision		Choice Bronze Standard POS Value Bronze Standard POS	
In-Network (INN)/Out-of-Network (OON)	In-Network	Out-of-Network	In-Network	Out-of-Network
VALUE BASICS				
Teladoc Virtual Care Visits 24/7/365	No-Cost	50% after ded	No-Cost	50% after ded
Annual Wellness Visit - Adults	No-Cost	50%	No-Cost	50%
Routine Preventive Screenings - Children & Adults	No-Cost	50%	No-Cost	50%
Routine Vision Exam - Children (Ages under 26)	$70	50% after ded	$70 after ded	50% after ded
Routine Eyewear - Children (Ages under 26)	50% after ded	50% after ded	No-Cost	50% after ded
Preventive Prescription Drugs	No-Cost	50% after ded	No-Cost	50% after ded
24-Hour Nurse Advice Line	No-Cost	N/A	No-Cost	N/A
BENEFITS AND COST SHARE HIGHLIGHTS				
Deductible (Ind/Fam)	$7,000 / $14,000	$15,000 / $30,000	$7,000 / $14,000	$13,100 / $26,200
Drug Deductible (Ind/Fam)	Comb. w/ Med	Comb. w/ Med	Comb. w/ Med	Comb. w/ Med
Out of Pocket Max (Ind/Fam)	$9,200 / $18,400	$20,000 / $40,000	$10,000 / $20,000	$18,200 / $36,400
Emergency Room Facility	45% after ded	45% after INN ded	$450 after ded	$450 after INN ded
Urgent Care Services	$100	50% after ded	$75	50% after ded

**Retail Rx (cost share based on 30 day supply per prescription) Insulin and non-insulin drugs are covered up to a max of $25 for each 30-day supply.
§ Mail-order is available for non-specialty drugs marked "MAIL" on the formulary. For mail-order Rx, a 90-day supply is provided at three times (3x) the 30-day retail cost-sharing amount.

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In-Network (INN)/Out-of-Network (OON)	Choice Bronze Alternative POS with Dental and Vision		Choice Bronze Standard POS Value Bronze Standard POS	
	In-Network	Out-of-Network	In-Network	Out-of-Network
INPATIENT SERVICES				
Inpatient Facility Fee **Professional Fees May Apply*	45% after ded	50% after ded	$500 per day after ded ($1,000 max per admission)	50% per admission after ded
OUTPATIENT PROFESSIONAL OFFICE VISITS SERVICES				
Primary Care	$50	50% after ded	$50	50% after ded
Specialty Care	$70 after ded	50% after ded	$70 after ded	50% after ded
Rehabilitative and Habilitative Services	$30 after ded	50% after ded	$30 after ded	50% after ded
Mental / Behavioral Health Services / Substance Use Disorder Services	$50	50% after ded	$50	50% after ded

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In-Network (INN)/Out-of-Network (OON)	Choice Bronze Alternative POS with Dental and Vision		Choice Bronze Standard POS Value Bronze Standard POS	
	In-Network	Out-of-Network	In-Network	Out-of-Network
OUTPATIENT HOSPITAL FACILITY SERVICES				
Outpatient Facility Fee	45% after ded at an Outpatient Hospital Facility $500 after ded at an Ambulatory Surgery Center	50% after ded	$500 after ded at an Outpatient Hospital Facility $300 after ded at an Ambulatory Surgery Center	50% after ded
Outpatient Professional Fee	45% after ded at an Outpatient Hospital Facility $0 after ded at an Ambulatory Surgery Center	50% after ded	$0 after ded	50% after ded
Advanced Imaging and Specialized Scanning Services	45% after ded at an Outpatient Facility Center $75 after ded at Independent Provider	50% after ded	$75 after ded up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	50% after ded
Routine X- Ray and Diagnostic Services	45% after ded at an Outpatient Facility Center $70 after ded at Independent Provider	50% after ded	$40 after ded	50% after ded
Laboratory Tests	$25 after ded	50% after ded	$20	50% after ded

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In-Network (INN)/Out-of-Network (OON)	Choice Bronze Alternative POS with Dental and Vision		Choice Bronze Standard POS Value Bronze Standard POS	
	In-Network	Out-of-Network	In-Network	Out-of-Network
PRESCRIPTION DRUGS§				
Preventive Drugs	No charge	50% after ded	No charge	50% after ded
Preferred Generic Drugs	$30	50% after ded	$15	50% after ded
Preferred Brand Drugs	$100 after ded	50% after ded	$50	50% after ded
Non-Preferred Drugs	50% after ded	50% after ded	50% after ded	50% after ded
Specialty Drugs	50% after ded ($500 max per prescription)	50% after ded	50% after ded ($500 max per prescription)	50% after ded

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	Choice Bronze Standard POS HSA Value Bronze Standard POS HSA		Choice Silver Standard POS Value Silver Standard POS		Choice Silver Standard POS (CSR 73%) Value Silver Standard POS (CSR 73%)	
In-Network (INN)/Out-of-Network (OON)	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
VALUE BASICS						
Teladoc Virtual Care Visits 24/7/365	0% after ded	50% after ded	No-Cost	40% after ded	No-Cost	40% after ded
Annual Wellness Visit - Adults	No-Cost	50%	No-Cost	40%	No-Cost	40%
Routine Preventive Screenings - Children & Adults	No-Cost	50%	No-Cost	40%	No-Cost	40%
Routine Vision Exam - Children (Ages under 26)	20% after ded	50% after ded	$60	40% after ded	$60	40% after ded
Routine Eyewear - Children (Ages under 26)	$0 after ded	50% after ded	No-Cost	50% after ded	No-Cost	50% after ded
Preventive Prescription Drugs	No-Cost	50% after ded	No-Cost	40% after RX ded	No-Cost	40% after RX ded
24-Hour Nurse Advice Line	No-Cost	N/A	No-Cost	N/A	No-Cost	N/A
BENEFITS AND COST SHARE HIGHLIGHTS						
Deductible (Ind/Fam)	$6,500 / $13,000	$13,000 / $26,000	$5,000 / $10,000	$10,000 / $20,000	$5,000 / $10,000	$10,000 / $20,000
Drug Deductible (Ind/Fam)	Comb. w/ Med	Comb. w/ Med	$250 / $500	$500 / $1,000	$250 / $500	$500 / $1,000
Out of Pocket Max (Ind/Fam)	$7,225 / $14,450	$14,450 / $28,900	$9,400 / $18,800	$18,200 / $36,400	$7,675 / $15,350	$18,200 / $36,400
Emergency Room Facility	20% after ded	20% after INN ded	$450 after ded	$450 after INN ded	$450 after ded	$450 after INN ded
Urgent Care Services	20% after ded	50% after ded	$75	40% after ded	$75	40% after ded

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	Choice Bronze Standard POS HSA Value Bronze Standard POS HSA		Choice Silver Standard POS Value Silver Standard POS		Choice Silver Standard POS (CSR 73%) Value Silver Standard POS (CSR 73%)	
In-Network (INN)/Out-of-Network (OON)	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
INPATIENT SERVICES						
Inpatient Facility Fee **Professional Fees May Apply*	20% after ded	50% after ded	$500 after ded ($2,000 max per admission)	40% after ded	$500 after ded ($2,000 max per admission)	40% after ded
OUTPATIENT PROFESSIONAL OFFICE VISITS SERVICES						
Primary Care	20% after ded	50% after ded	$45	40% after ded	$45	40% after ded
Specialty Care	20% after ded	50% after ded	$60	40% after ded	$60	40% after ded
Rehabilitative and Habilitative Services	20% after ded	50% after ded	$30	40% after ded	$30	40% after ded
Mental / Behavioral Health Services / Substance Use Disorder Services	20% after ded	50% after ded	$45	40% after ded	$45	40% after ded

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	Choice Bronze Standard POS HSA Value Bronze Standard POS HSA		Choice Silver Standard POS Value Silver Standard POS		Choice Silver Standard POS (CSR 73%) Value Silver Standard POS (CSR 73%)	
In-Network (INN)/Out-of-Network (OON)	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
OUTPATIENT HOSPITAL FACILITY SERVICES						
Outpatient Facility Fee	20% after ded	50% after ded	$500 after ded at an Outpatient Hospital Facility $300 after ded at an Ambulatory Surgery Center	40% after ded	$500 after ded at an Outpatient Hospital Facility $300 after ded at an Ambulatory Surgery Center	40% after ded
Outpatient Professional Fee	20% after ded	50% after ded	$0 after ded	40% after ded	$0 after ded	40% after ded
Advanced Imaging and Specialized Scanning Services	20% after ded	50% after ded	$75 up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	40% after ded	$75 up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	40% after ded
Routine X- Ray and Diagnostic Services	20% after ded	50% after ded	$40 after ded	40% after ded	$40 after ded	40% after ded
Laboratory Tests	20% after ded	50% after ded	$25	40% after ded	$25	40% after ded

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	Choice Bronze Standard POS HSA Value Bronze Standard POS HSA		Choice Silver Standard POS Value Silver Standard POS		Choice Silver Standard POS (CSR 73%) Value Silver Standard POS (CSR 73%)	
In-Network (INN)/Out-of-Network (OON)	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
PRESCRIPTION DRUGS§						
Preventive Drugs	No charge	50% after ded	No charge	40% after RX ded	No charge	40% after RX ded
Preferred Generic Drugs	20% after ded	50% after ded	$10	40% after RX ded	$10	40% after RX ded
Preferred Brand Drugs	25% after ded	50% after ded	$50 after RX ded	40% after RX ded	$50 after RX ded	40% after RX ded
Non-Preferred Drugs	30% after ded	50% after ded	$75 after RX ded	40% after RX ded	$75 after RX ded	40% after RX ded
Specialty Drugs	30% after ded ($500 max per prescription)	50% after ded	20% after RX ded ($200 max per prescription)	40% after RX ded	20% after RX ded ($100 max per prescription)	40% after RX ded

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	Choice Silver Standard POS (CSR 87%)		Choice Silver Standard POS (CSR 94%)		Choice Covered Connecticut Program (87)	
	Value Silver Standard POS (CSR 87%)		Value Silver Standard POS (CSR 94%)		Value Covered Connecticut Program (87)	
In-Network (INN)/Out-of-Network (OON)	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
VALUE BASICS						
Teladoc Virtual Care Visits 24/7/365	No-Cost	40% after ded	No-Cost	40% after ded	No-Cost	State: 40% after ded Member: $0
Annual Wellness Visit - Adults	No-Cost	40%	No-Cost	40%	No-Cost	State: 40% Member: $0
Routine Preventive Screenings - Children & Adults	No-Cost	40%	No-Cost	40%	No-Cost	State: 40% Member: $0
Routine Vision Exam - Children (Ages under 26)	$45	40% after ded	$30	40% after ded	State: $45 Member: $0	State: 40% after ded Member: $0
Routine Eyewear - Children (Ages under 26)	No-Cost	50% after ded	No-Cost	50% after ded	No-Cost	State: 50% after ded Member: $0
Preventive Prescription Drugs	No-Cost	40% after RX ded	No-Cost	40% after RX ded	No-Cost	State: 40% after RX ded Member: $0
24-Hour Nurse Advice Line	No-Cost	N/A	No-Cost	N/A	No-Cost	N/A

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	Choice Silver Standard POS (CSR 87%) / Value Silver Standard POS (CSR 87%)		Choice Silver Standard POS (CSR 94%) / Value Silver Standard POS (CSR 94%)		Choice Covered Connecticut Program (87) / Value Covered Connecticut Program (87)	
In-Network (INN)/Out-of-Network (OON)	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
BENEFITS AND COST SHARE HIGHLIGHTS						
Deductible (Ind/Fam)	$415 / $830	$10,000 / $20,000	$0	$10,000 / $20,000	State: $415 / $830 Member: $0	State: $10,000 / $20,000 Member: $0
Drug Deductible (Ind/Fam)	$50 / $100	$500 / $1,000	$0	$500 / $1,000	State: $50 / $100 Member: $0	State: $500 / $1,000 Member: $0
Out of Pocket Max (Ind/Fam)	$2,950 / $5,900	$18,200 / $36,400	$1,350 / $2,700	$18,200 / $36,400	State: $2,950 / $5,900 Member: $0	State: $18,200 / $36,400 Member: $0
Emergency Room Facility	$150 after ded	$150 after INN ded	$50	$50	State: $150 after ded Member: $0	State: $150 after INN ded Member: $0
Urgent Care Services	$35	40% after ded	$25	40% after ded	State: $35 Member: $0	State: 40% after ded Member: $0

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In-Network (INN)/Out-of-Network (OON)	Choice Silver Standard POS (CSR 87%) / Value Silver Standard POS (CSR 87%) In-Network	Choice Silver Standard POS (CSR 87%) / Value Silver Standard POS (CSR 87%) Out-of-Network	Choice Silver Standard POS (CSR 94%) / Value Silver Standard POS (CSR 94%) In-Network	Choice Silver Standard POS (CSR 94%) / Value Silver Standard POS (CSR 94%) Out-of-Network	Choice Covered Connecticut Program (87) / Value Covered Connecticut Program (87) In-Network	Choice Covered Connecticut Program (87) / Value Covered Connecticut Program (87) Out-of-Network
INPATIENT SERVICES						
Inpatient Facility Fee **Professional Fees May Apply*	$100 after ded ($400 max per admission)	40% after ded	$75 ($300 max per admission)	40% after ded	State: $100 day / $400 admit after ded Member: $0	State: 40% after ded Member: $0
OUTPATIENT PROFESSIONAL OFFICE VISITS SERVICES						
Primary Care	$35	40% after ded	$15	40% after ded	State:$35 Member: $0	State: 40% after ded Member: $0
Specialty Care	$50	40% after ded	$30	40% after ded	State: $50 Member: $0	State: 40% after ded Member: $0
Rehabilitative and Habilitative Services	$20	40% after ded	$20	40% after ded	State: $20 Member: $0	State: 40% after ded Member: $0
Mental / Behavioral Health Services / Substance Use Disorder Services	$35	40% after ded	$15	40% after ded	State:$35 Member: $0	State: 40% after ded Member: $0

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	Choice Silver Standard POS (CSR 87%) / Value Silver Standard POS (CSR 87%)		Choice Silver Standard POS (CSR 94%) / Value Silver Standard POS (CSR 94%)		Choice Covered Connecticut Program (87) / Value Covered Connecticut Program (87)	
In-Network (INN)/Out-of-Network (OON)	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
OUTPATIENT HOSPITAL FACILITY SERVICES						
Outpatient Facility Fee	$100 after ded at an Outpatient Hospital Facility $60 after ded at an Ambulatory Surgery Center	40% after ded	$75 at an Outpatient Hospital Facility $45 at an Ambulatory Surgery Center	40% after ded	State: $100 after ded at an Outpatient Hospital Facility Member: $0 State: $60 after ded at an Ambulatory Surgery Center Member: $0	State: 40% after ded Member: $0
Outpatient Professional Fee	$0 after ded	40% after ded	$0	40% after ded	State: $0 after ded Member: $0	State: 40% after ded Member: $0
Advanced Imaging and Specialized Scanning Services	$60 up to a combined annual maximum of $360 for MRI and CAT scans; $400 for PET scans	40% after ded	$50 up to a combined annual maximum of $350 for MRI and CAT scans; $400 for PET scans	40% after ded	State: $60 up to a combined annual maximum of $360 for MRI and CAT scans; $400 for PET scans Member: $0	State: 40% after ded Member: $0
Routine X- Ray and Diagnostic Services	$30 after ded	40% after ded	$25	40% after ded	State: $30 after ded Member: $0	State: 40% after ded Member: $0
Laboratory Tests	$15	40% after ded	$10	40% after ded	State: $15 Member: $0	State: 40% after ded Member: $0

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In-Network (INN)/Out-of-Network (OON)	Choice Silver Standard POS (CSR 87%) Value Silver Standard POS (CSR 87%) In-Network	Choice Silver Standard POS (CSR 87%) Value Silver Standard POS (CSR 87%) Out-of-Network	Choice Silver Standard POS (CSR 94%) Value Silver Standard POS (CSR 94%) In-Network	Choice Silver Standard POS (CSR 94%) Value Silver Standard POS (CSR 94%) Out-of-Network	Choice Covered Connecticut Program (87) Value Covered Connecticut Program (87) In-Network	Choice Covered Connecticut Program (87) Value Covered Connecticut Program (87) Out-of-Network
PRESCRIPTION DRUGS§						
Preventive Drugs	No charge	40% after RX ded	No charge	40% after RX ded	No charge	State: 40% after RX ded Member: $0
Preferred Generic Drugs	$10	40% after RX ded	$5	40% after RX ded	State: $10 Member: $0	State: 40% after RX ded Member: $0
Preferred Brand Drugs	$25	40% after RX ded	$10	40% after RX ded	State: $25 Member: $0	State: 40% after RX ded Member: $0
Non-Preferred Drugs	$40 after RX ded	40% after RX ded	$30	40% after RX ded	State: $40 after RX ded Member: $0	State: 40% after RX ded Member: $0
Specialty Drugs	20% after RX ded ($60 max per prescription)	40% after RX ded	20% ($60 max per prescription)	40% after RX ded	State: 20% after RX ded ($60 max per prescription) Member: $0	State: 40% after RX ded Member: $0

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	Choice Covered Connecticut Program (94) / Value Covered Connecticut Program (94)		Choice Gold Standard POS / Value Gold Standard POS		Choice Gold Alternative POS	
In-Network (INN)/Out-of-Network (OON)	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
VALUE BASICS						
Teladoc Virtual Care Visits 24/7/365	No-Cost	State: 40% after ded Member: $0	No-Cost	30% after ded	No-Cost	50% after ded
Annual Wellness Visit - Adults	No-Cost	State: 40% Member: $0	No-Cost	30%	No-Cost	50%
Routine Preventive Screenings - Children & Adults	No-Cost	State: 40% Member: $0	No-Cost	30%	No-Cost	50%
Routine Vision Exam - Children (Ages under 26)	State: $30 Member: $0	State: 40% after ded Member: $0	$40	30% after ded	$50	50% after ded
Routine Eyewear - Children (Ages under 26)	No-Cost	State: 50% after ded Member: $0	No-Cost	50% after ded	50% after ded	50% after ded
Preventive Prescription Drugs	No-Cost	State: 40% after RX ded Member: $0	No-Cost	30% after RX ded	No-Cost	50% after RX ded
24-Hour Nurse Advice Line	No-Cost	N/A	No-Cost	N/A	No-Cost	N/A

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	Choice Covered Connecticut Program (94) / Value Covered Connecticut Program (94)		Choice Gold Standard POS / Value Gold Standard POS		Choice Gold Alternative POS	
In-Network (INN)/Out-of-Network (OON)	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
BENEFITS AND COST SHARE HIGHLIGHTS						
Deductible (Ind/Fam)	$0	State: $10,000 / $20,000 Member: $0	$1,200 / $2,400	$3,000 / $6,000	$2,000 / $4,000	$7,000 / $14,000
Drug Deductible (Ind/Fam)	$0	State: $500 / $1,000 Member: $0	$50 / $100	$350 / $700	$75 / $150	$500 / $1,000
Out of Pocket Max (Ind/Fam)	State: $1,350 / $2,700 Member: $0	State: $18,200 / $36,400 Member: $0	$7,375 / $14,750	$14,750 / $29,500	$7,900 / $15,800	$12,000 / $24,000
Emergency Room Facility	State: $50 Member: $0	State: $50 Member: $0	$400	$400	30% after ded	30% after INN ded
Urgent Care Services	State: $25 Member: $0	State: 40% after ded Member: $0	$50	30% after ded	30%	50% after ded

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	Choice Covered Connecticut Program (94) / Value Covered Connecticut Program (94)		Choice Gold Standard POS / Value Gold Standard POS		Choice Gold Alternative POS	
In-Network (INN)/Out-of-Network (OON)	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
INPATIENT SERVICES						
Inpatient Facility Fee **Professional Fees May Apply*	State: $75 ($300 max per admission) Member: $0	State: 40% after ded Member: $0	$500 after ded ($1,000 per admission)	30% after ded	30% after ded	50% after ded
OUTPATIENT PROFESSIONAL OFFICE VISITS SERVICES						
Primary Care	State: $15 Member: $0	State: 40% after ded Member: $0	$20	30% after ded	$40	50% after ded
Specialty Care	State: $30 Member: $0	State: 40% after ded Member: $0	$40	30% after ded	$50	50% after ded
Rehabilitative and Habilitative Services	State: $20 Member: $0	State: 40% after ded Member: $0	$20	30% after ded	30% after ded	50% after ded
Mental / Behavioral Health Services / Substance Use Disorder Services	State: $15 Member: $0	State: 40% after ded Member: $0	$20	30% after ded	$40	50% after ded

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ConnectiCare Benefits At A Glance

ConnectiCare

In-Network (INN)/ Out-of-Network (OON)	Choice Covered Connecticut Program (94) / Value Covered Connecticut Program (94)		Choice Gold Standard POS / Value Gold Standard POS		Choice Gold Alternative POS	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
OUTPATIENT HOSPITAL FACILITY SERVICES						
Outpatient Facility Fee	State: $75 at an Outpatient Hospital Facility Member: $0 State: $45 at an Ambulatory Surgery Center Member: $0	State: 40% after ded Member: $0	$500 after ded at an Outpatient Hospital Facility $300 after ded at an Ambulatory Surgery Center	30% after ded	30% after ded at an Outpatient Facility $250 at an Ambulatory Surgery Center	50% after ded
Outpatient Professional Fee	$0	State: 40% after ded Member: $0	$0 after ded	30% after ded	30% after ded at an Outpatient Facility $0 at an Ambulatory Surgery Center	50% after ded
Advanced Imaging and Specialized Scanning Services	State: $50 up to a combined annual maximum of $350 for MRI and CAT scans; $400 for PET scans Member: $0	State: 40% after ded Member: $0	$65 up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	30% after ded	30% after ded at an Outpatient Facility $75 after ded (5 copay max) at Independent Provider	50% after ded
Routine X- Ray and Diagnostic Services	State: $25 Member: $0	State: 40% after ded Member: $0	$40 after ded	30% after ded	30% after ded at an Outpatient Facility $50 at Independent Provider	50% after ded
Laboratory Tests	State: $10 Member: $0	State: 40% after ded Member: $0	$10	30% after ded	$10	50% after ded

**Retail Rx (cost share based on 30 day supply per prescription) Insulin and non-insulin drugs are covered up to a max of $25 for each 30-day supply.
§ Mail-order is available for non-specialty drugs marked "MAIL" on the formulary. For mail-order Rx, a 90-day supply is provided at three times (3x) the 30-day retail cost-sharing amount.

SERVICES WITHOUT ANY DEDUCTIBLE

2026

ConnectiCare Benefits At A Glance

ConnectiCare

	Choice Covered Connecticut Program (94) / Value Covered Connecticut Program (94)		Choice Gold Standard POS / Value Gold Standard POS		Choice Gold Alternative POS	
In-Network (INN)/Out-of-Network (OON)	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
PRESCRIPTION DRUGS§						
Preventive Drugs	No charge	State: 40% after RX ded Member: $0	No charge	30% after RX ded	No charge	50% after RX ded
Preferred Generic Drugs	State: $5 Member: $0	State: 40% after RX ded Member: $0	$5	30% after RX ded	$10	50% after RX ded
Preferred Brand Drugs	State: $10 Member: $0	State: 40% after RX ded Member: $0	$35	30% after RX ded	$40	50% after RX ded
Non-Preferred Drugs	State: $30 Member: $0	State: 40% after RX ded Member: $0	$60	30% after RX ded	20% after ded	50% after RX ded
Specialty Drugs	State: 20% ($60 max per prescription) Member: $0	State: 40% after RX ded Member: $0	20% after RX ded ($100 max per prescription)	30% after RX ded	20% after ded ($750 max per prescription)	50% after RX ded

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SERVICES WITHOUT ANY DEDUCTIBLE

2026

ConnectiCare Benefits At A Glance

ConnectiCare

	Choice Catastrophic POS with Dental and Vision	
In-Network (INN)/Out-of-Network (OON)	In-Network	Out-of-Network
VALUE BASICS		
Teladoc Virtual Care Visits 24/7/365	$0 after ded	50% after ded
Annual Wellness Visit - Adults	No-Cost	50%
Routine Preventive Screenings - Children & Adults	No-Cost	50%
Routine Vision Exam - Children (Ages under 26)	$0 after ded	50% after ded
Routine Eyewear - Children (Ages under 26)	$0 after ded	50% after ded
Preventive Prescription Drugs	No-Cost	50% after ded
24-Hour Nurse Advice Line	No-Cost	N/A
BENEFITS AND COST SHARE HIGHLIGHTS		
Deductible (Ind/Fam)	$10,600 / $21,200	$15,000 / $30,000
Drug Deductible (Ind/Fam)	Comb. w/ Med	Comb. w/ Med
Out of Pocket Max (Ind/Fam)	$10,600 / $21,200	$20,000 / $40,000
Emergency Room Facility	$0 after ded	$0 after INN ded
Urgent Care Services	$0 after ded	50% after ded

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SERVICES WITHOUT ANY DEDUCTIBLE

ConnectiCare Benefits At A Glance

ConnectiCare

In-Network (INN)/Out-of-Network (OON)	Choice Catastrophic POS with Dental and Vision	
	In-Network	Out-of-Network
INPATIENT SERVICES		
Inpatient Facility Fee **Professional Fees May Apply*	$0 after ded	50% after ded
OUTPATIENT PROFESSIONAL OFFICE VISITS SERVICES		
Primary Care	$30 first 3 visits then $0 after ded	50% after ded
Specialty Care	$0 after ded	50% after ded
Rehabilitative and Habilitative Services	$0 after ded	50% after ded
Mental / Behavioral Health Services / Substance Use Disorder Services	$30 first 3 visits then $0 after ded (combined with PCP)	50% after ded
OUTPATIENT HOSPITAL FACILITY SERVICES		
Outpatient Facility Fee	$0 after ded	50% after ded
Outpatient Professional Fee	$0 after ded	50% after ded
Advanced Imaging and Specialized Scanning Services	$0 after ded	50% after ded
Routine X- Ray and Diagnostic Services	$0 after ded	50% after ded
Laboratory Tests	$0 after ded	50% after ded

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SERVICES WITHOUT ANY DEDUCTIBLE

ConnectiCare Benefits At A Glance

In-Network (INN)/Out-of-Network (OON)	Choice Catastrophic POS with Dental and Vision	
	In-Network	Out-of-Network
PRESCRIPTION DRUGS§		
Preventive Drugs	No charge	50% after ded
Preferred Generic Drugs	$0 after ded	50% after ded
Preferred Brand Drugs	$0 after ded	50% after ded
Non-Preferred Drugs	$0 after ded	50% after ded
Specialty Drugs	$0 after ded	50% after ded

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SERVICES WITHOUT ANY DEDUCTIBLE